know that what Mr. Kaiser says will happen in Permanente usually happens.

Here, then, in our opinion, is the pattern for lay practice, control and direction of a profession. We need not argue the public interest factors in this condition. They have long since been decided and repeatedly reaffirmed by the courts. How many profit-minded laymen will see in the "Permanente idea" the opportunity to "reverse the usual economics of medicine" for themselves? And what will they do with it? Whom will they exploit? And to whom will they be answerable?

Typical of the mechanistic "efficiency," of the unprofessional approach of Permanente to medicine, is its solicitation of patients. We assume it is unnecessary to quote or interpret the Principles of Medical Ethics of the American Medical Association to our readers. Patients in every group sold by Permanente are solicited, with the full knowledge of "Permanente" but not with the full knowledge of all of the *doctors* of Permanente. Many members of these employed groups are currently under the treatment of other doctors. Our studies of Permanente reveal that either the ethical prohibition of solicitation of patients by any doctor is wrong, or all Permanente doctors are unprofessional and unethical. Doctors outside Permanente may not solicit patients; Permanente doctors solicit their patients.

Much is made of the financial success of Permanente. Captive doctors, seeing and treating many patients, is one reason. Interns and residents treat some—how many we do not know. Another reason for financial success is that many subscribers who enroll do so reluctantly, as minority members of employed groups. These persons continue to go to their private physicians, keeping Permanente insurance in the background for catastrophes. It is difficult to find a private physician in the East Bay "stronghold" of Permanente who does not have Permanente plan members who continue — even for major operations—with their personal physicians. Each such visit, each such treatment paid for by the patient, is a contribution to Permanente's spectacular financial success.

If the values of the art and science of medicine can be measured by an industrialist's standards of production and efficiency and profit, Permanente is an unqualified success. But medicine has other standards.

The Boston editorialist believes that closed panel plans may provide "more and better medical care." It has not yet been produced by these plans. "Lower cost"? Yes, in premium. "Maintain the dignity of doctor and patient"? Former Permanente doctors have regained their dignity in private practice and lose no opportunity to dispute that claim.

As to the patient's dignity: the closed-panel plan tells him he can't select his own doctor. Permanente can do it better, despite its doctor turn-over record. The patient is assigned to a doctor, is told by the plan what treatment he gets, by whom and where. He is *not* free to exercise his own judgment and choice. Can this maintain his dignity?

Our confidence in the good judgment of the American people is such that we are not deeply concerned about the future of closed-panel plans. The "Permanente idea" is *not* new. The history of nearly every medical society will reveal the same problem under the name of "Lodge practice," with inevitably the same result as we predict for the closed-panel plan. The people will make the final determination. Our studies show they want their personal physicians, whose incentive is to serve them and not some third party—union leader, government agency, lodge master or industrialist.

So, we too would join the *New England Journal of Medicine* in counseling study of closed-panel plans. The more thinking and study, the more experience doctors and patients have with closed-panel plans, the more each will realize that it is pointless to "erect further defenses against the encroachment of socialized medicine" if those defenses consist mainly of instituting the worst dangers of socialized medicine.

New Approach

MOST SIGNIFICANT development emerging from the 1952 Interim Session of the C.M.A. House of Delegates was the proposed new approach to the problem of providing insurance against the costs of medical and hospital care. The C.P.S. Study Committee, crystallizing its intense research of the past eighteen months, offered a plan which is startling in some aspects but which basically appears as a new and sound appraisal in this still experimental field.

The committee report proposes (a) that indemnity insurance be utilized as the carrying agent, (b) that co-insurance govern the underwriting procedure, with the policyholder accepting his legitimate share of the risk, (c) that "average fees" be worked out, successively, by individual physicians, by county or regional areas, and by the state as a whole, and (d) that deviations upward from accepted "average fees" be undertaken only with the knowledge and consent of the patient. Failure to accomplish the last of these proposals would be *prima facie* cause for the patient to seek the counsel and aid of the

professional conduct committee of the county medical society.

While none of the above proposals is new in itself, the combination under this suggested program represents a new concept in the search to provide top-flight medical and hospital care under conditions and at fees which are acceptable to, and may be afforded by, the general public.

In the next few months the county medical societies will ask themselves and their members whether or not they wish to accept this far-reaching proposal. Most knotty problem apparent in the coming deliberations will be the establishment of "average fees" by individual physicians and by their county societies. Upon this branch of the proposal hangs a large measure of the potential success of the entire program.

The entire text of the study committee's report appears elsewhere in this issue of CALIFORNIA MEDICINE. Every member should read this document carefully, repeating the process as needed to assure a complete understanding of the philosophy developed after months of study, testimony, discussion and deliberation. Here is proposed a new approach to the ever-growing problem of health insurance. The considered opinions of all county medical societies will be vital in determining whether or not this plan offers the ideal path for medicine to take in leading the way to a great public service.

Increase in Cancer Incidence

FOLLOWING COMPLETION of a cancer survey in the Birmingham, Alabama, area in 1948, National Cancer Institute reports a 71 per cent increase in incidence and a 50 per cent increase in total cases treated since the last survey there in 1938.

Dr. John R. Heller, institute director, attributes the increases partly to better reporting by physicians, improved diagnostic and case-finding methods, and aging of the population. ". . . The survey shows that more cancer patients received hospital care in 1948 than in 1938, due in part to the increase in hospital facilities in Birmingham," he said.

The survey, eighth in a series by the Institute, was carried out with help from the Jefferson County Medical Society, the Jefferson County Hospital and Birmingham, Jefferson County and State Health Departments. — *From the A.M.A. Capitol Clinic.*